TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
BAYLOR SURGICARE AT OAKMONT

Respondent Name
MIDWEST INSURANCE CO

MFDR Tracking Number
M4-17-0296-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 04, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) has reviewed your allegation relating to: Failure to timely take final action on a request for reconsideration of a medical bill action within 30 days of receipt.

At this time, the complaint is closed and no further action will be taken by the TDI-DWC. However, without revealing your identity, we have notified Midwest Insurance Co. We also encouraged Midwest Insurance Co to review their role and responsibilities relating to the above allegation to ensure they are in compliance with the applicable portions of the Texas Labor Code and/or 28 Texas Administrative Code."

Amount in Dispute: $1,060.63

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Late filing as to DOS: The provider's request was not datestamped as received by DWC MRD until 10/4/16. Consequently, it is not timely as to the DOS at issue per Rule 133.307(c)(1)(A). The provider has waived its right for MFDR. PLEASE DISMISS."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 13, 2015	CPT Code 25320	$730.55	$0.00
June 11, 2015	CPT Code 20680	$330.08	

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 850-300 – Reviewed based on Guidelines set forth per the applicable State Workers' Compensation Fee Schedule $1,878.64
   - P12 – Workers' compensation jurisdictional fee schedule adjustment. Note: if adjustment is as the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code identification Segment

Issues

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states:

   Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.

   (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

   The date of the services in dispute is May 13, 2015 and June 11, 2015. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on October 04, 2016. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	11/3/2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.